Commissioner's Task Force on Abstinence Education

Final Report

Presented to

John A. Stephen, Commissioner

Department of Health and Human Services

April 2004

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EXECUTIVE SUMMARY

Section 510 (Abstinence Education Grant Program) of the Social Security Act became law in 1996 as part of welfare to work reform legislation. This federal program provides money to states that can be used to provide abstinence-only education and, at the option of States, pay for mentoring, counseling, and adult supervision to promote abstinence from sexual activity. By law this program is designed to place an emphasis on groups with a higher probability of having children before marriage. Since the inception of the program in 1997 New Hampshire has been awarded $545,637 in federal funding.

In 2003 the Health and Human Services Oversight Committee raised concerns abut the direction of the abstinence program and the value received for the money spent. In response, DHHS Commissioner John A. Stephen convened a task force for the purpose of examining the program. The Task Force, consisting of 20 members with a background or interest in abstinence-only education, had as its mission the top-to-bottom review of the existing state abstinence program with the intention of improving how these critical services are delivered to the youth of our state. The ultimate goal of the Task Force is to increase the percentage of New Hampshire teens that refrain from sexual activity.

The Task Force met five times between November 2003 and April 2004 for the purposes of identifying the policy issues in need of review, assigning these issues to task force subgroups for study, reviewing the work of the subgroups, and approving a set of final recommendations for the improvement of the state abstinence program.

The Task Force recommends the following:

- Focus New Hampshire's Section 510 program on funding the work of community programs directly involved with teaching abstinence-only to young people. A priority must be placed on populations at greatest risk, funds must be made available in a way that is "user-friendly" to applicants, and the DHHS needs to devote the time and effort needed to coordinate the Section 510 Program.
- Once community program needs are met, continue on with a reduced media program, but refocus the message on promoting youth participation in community level abstinence programs. Other abstinence-only mass media messages should be funded only after the needs of the community programs are met.
- Abstinence curricula must be more than a "just say no" message, and teach the social and decision making skills young people need to abstain from sexual activity.
- Maintain public oversight over the Section 510 program through the committee and periodic presentations to the HHS Oversight Committee established under RSA 126-A:13.
- The Task Force or similar group should seek additional support for statewide abstinence-only activities by applying for federal dollars available through the Special Projects of Regional or National Significance (SPRANS) Program.

INTRODUCTION

Vision Statement

To directly encourage young people to make decisions and choose behaviors that will enhance lifelong well being.

Goal of the Task Force

The goal of the Task Force is to increase the percentage of New Hampshire unwed youth that refrain from sexual activity.

Mission

The mission of the Task Force is to perform a top-to-bottom review of the existing state abstinence-only program funded by federal funds awarded under the authority of the Section 510 Abstinence Education Program with the intention of improving how these critical services are delivered to the youth of our state.

Study Methods

Recognizing the demands on time and given the need to complete this work as expeditiously as possible, Task Force members chose to meet for a limited number of times for the purposes of:

- Providing Task Force members with background information on the sexual activity of New Hampshire teens.
- Bringing all Task Force members to a common level of understanding of abstinence-only education and the reasons for it.
- Identifying the policy issues that needed review, and assigning these issues to subgroups for study, evaluation, and recommendation.
- Reviewing the work of the subgroups and approving a set of recommendations that will be provided to DHHS Commissioner John A. Stephen as part of this final report.

Description of the Section 510 Program

Section 510 of Title V of the Social Security Act became law in 1996 as part of welfare to work reform legislation. The Section 510 Program provides money to states that can be used to provide abstinence-only education and, at the option of States, pay for mentoring, counseling, and adult supervision to promote abstinence from sexual activity. The Section 510 Program is designed to place an emphasis on groups with a higher probability of having children before marriage.

By law, only the designated state agency (in the case of New Hampshire, that agency is the DHHS) may apply for Section 510 funds, although once received the funds can be reallocated to other providers as determined by the Legislature as part of the budget process and as approved by the Governor and Executive Council. Federal law also requires that these funds be matched by non-federal funds in a 3:4 ratio.

History of Section 510 program

Grant year 1997 funds were initially accepted and then returned to the federal government. For grant year 1998 Section 510 funds were used by a contractor to research abstinence curricula available in other states. For grant years 1999, 2000, 2001, and 2002 to date the funds were used to pay for the *Not Me, Not Now* media campaign. The grant award allows for the expenditure of funds for a period of 24 months after the award date, so funds are still being spent from the 2002 award. Grant year 2003 funds are yet to be expended, (since 2002 funds remain) and are currently programmed to be spent on additional media buys and community grants (spending plan may change based on Task Force recommendations). See Table 1 for details.

Table 1. Financial History of NH Section 510 Abstinence-only Education Program

Begin Date	End Date	Award	Contractor Exp	State Exp	Total Spent	State Match	Contractor Match	Media Match	Tech Adv. Group Match	Match Total [1]
10/97	9/99	$82,862 [2]	0	0	0	0	0	0	0	0
10/98	9/90	$82,862	$31,386	$1,136	$32,522	$10,865	$19,375	0	0	$30,240
10/99	9/01	$82,862	$82,814	$48	$82,862	$13,424	$19,375	0	$8,000	$40,799
10/00	9/02	$82,862	$82,587	$276	$82,862	$13,500	$19,231	$30,000	0	$62,731
10/01	9/03	$82,862	$82,523	$339	$82,862	$16,000	$19,000	$45,476	0	$80,476
10/02 [3]	9/04	$82,862	$3,263	0	$3,263	$16,118	$19,565	$43,149	0	$78,832
10/03 [3]	9/05	$48,465 [4]	0	0	0	$16,118	$19,565	$43,149	0	$85,582
Total		**$545,637**	**$282,573**	**$1,798**	**$284,371**	**$86,025**	**$116,111**	**$150,832**	**$8,000**	**$378,660**

NOTES: [1] Match totals combine proposed state match amounts from federal grant applications and other match amounts from state program reports and do not take into account the use of federal funds as approved carryover in subsequent state fiscal years; [2] Grant year 1997 funds returned to the federal government; [3] Matching amounts for grant years 2002 and 2003 based on proposed amounts from the federal grant applications; [4]Grant year 2003 application requested $96,930 in federal funds, $48,465 awarded to date for first two quarters of FFY2004.

What criteria define an acceptable abstinence only program?

Appendix A contains federal abstinence-only criteria A through H. These are set by Congress and cannot be changed by states. Appendix A also contains state criteria 1-10. The state criteria can be changed, but after review the Task Force found no reason to recommend doing so.

FINDINGS

Measurement Subgroup

Defining the Term "Sexual Activity"

Sexual activity in the context of an abstinence-only program requires a more comprehensive definition than simply intercourse because some sexually transmitted diseases (such as Human Papilloma Virus, or genital warts) spread through skin-to-skin contact as well as from the exchange of body fluids. Therefore, for the purposes of this report, the term "sexual activity" means all types of genital contact.

Sex and New Hampshire's young people

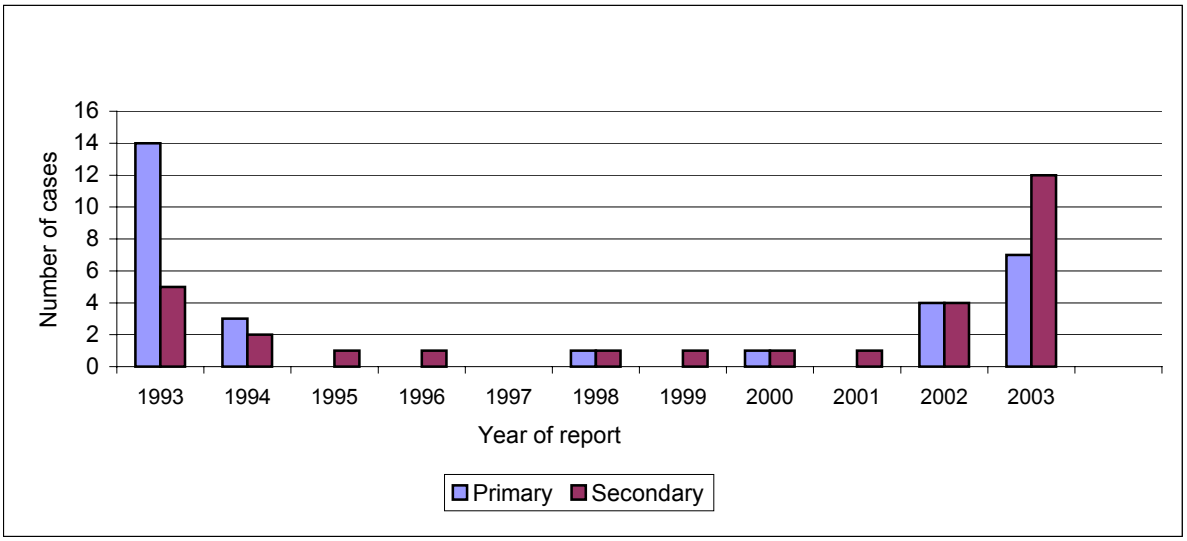
Sexually Transmitted Diseases

Sexually transmitted diseases (STDs), also known as venereal diseases, are among the most common infectious diseases in America. Thought to affect at least 13 million men and women in this country each year, more than 20 STDs have now been identified. While STDs affect men and women of all backgrounds and economic levels, they are most prevalent among teenagers and young adults. In fact, nearly two-thirds of all STDs occur in people younger than 25 years of age.

Research tells us that the incidence of STDs is rising in our country. Not only are people marrying later, but some young people are becoming sexually active earlier and divorce is more common. The net result of these three factors is that sexually active people are more likely to have multiple sex partners during their lives and are therefore may be at greater risk for developing STDs.

Unfortunately, New Hampshire is not immune to this national trend in increasing STD rates. A case in point is the recent rise in syphilis rates. There were 19 reported New Hampshire primary or secondary syphilis cases in 2003 as compared with 8 primary or secondary cases in 2002 (see Figure 1).

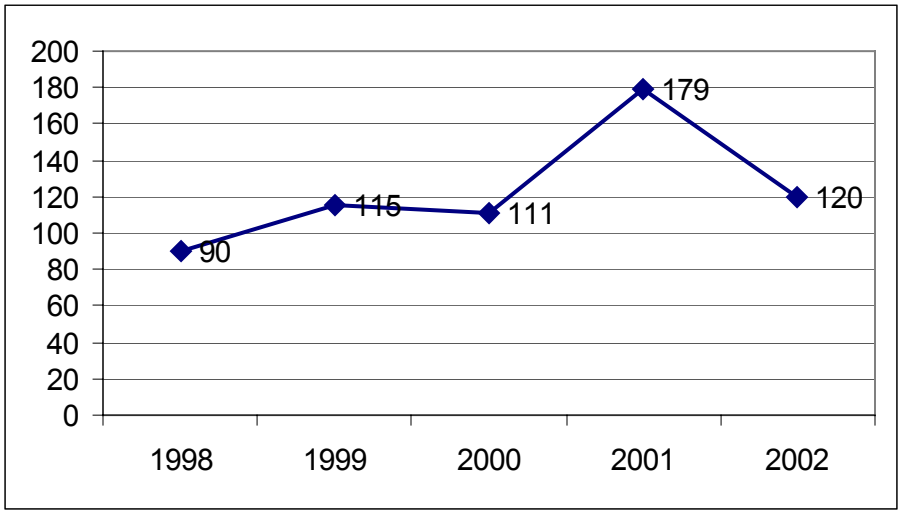
Figure 1. NH Primary and Secondary Syphilis 1993-2003



SOURCE: NH HIV/STD Prevention Bureau, OCPH, DHHS

On the other hand, gonorrhea cases in New Hampshire have remained relatively stable in the past five years (excluding 2001, when an increase in incidence was attributed to a cluster of cases in the city of Manchester). Figure 2 illustrates the frequency of reported cases in the past five years and the recent increase of 111 cases in 2000 to 120 cases in 2002. In recent years, the number of case reports, and infection rates by gender have been comparable.

Figure 2. NH Gonorrhea cases by year of report, 1998-2002

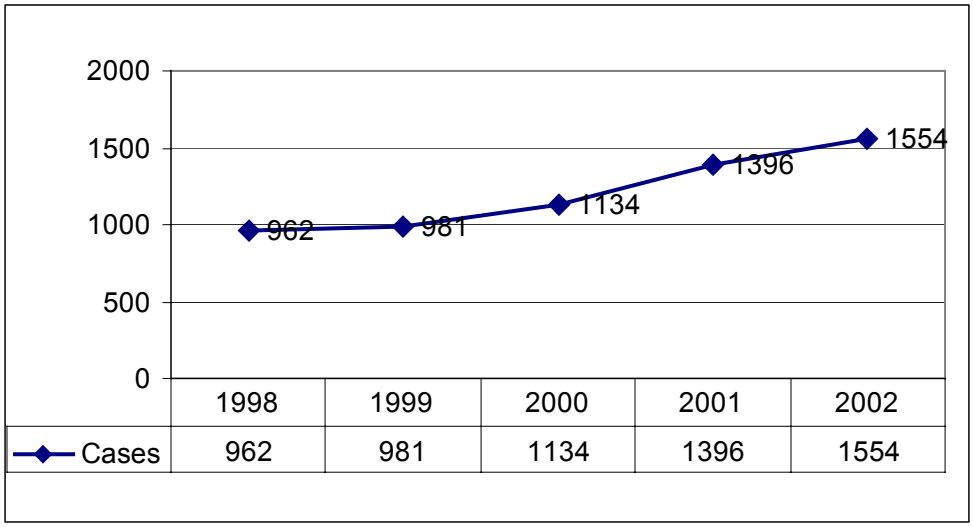


SOURCE: NH HIV/STD Prevention Bureau, OCPH, DHHS

Chlamydia infection (including chlamydial pelvic inflammatory disease) continues to be the most prevalent bacterial sexually transmitted disease in New Hampshire as well as the most frequently reported communicable disease in the state (Figure 3).

The incidence of chlamydia has increased overall as evidenced by the rates from 1998 of 77.8/100,000 to a rate of 125.7/100,000 in 2002. However, it is possible that at least some of this increase in chlamydia cases may be in part an artifact brought about by the adoption of more aggressive screening policies for young women and by the use of more sensitive tests.

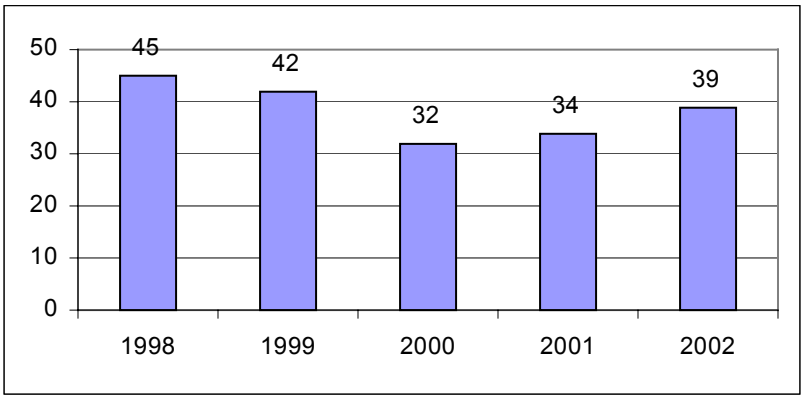
Figure 3. NH Chlamydia cases, by year of report, 1998-2002



SOURCE: NH HIV/STD Prevention Bureau, OCPH, DHHS

Similar to national trends, New Hampshire had observed an increase in reported AIDS cases beginning in 2001, with 34 cases in that calendar year. This upward trend continued in 2002 with 39 AIDS cases reported in the state (Figure 4). There have been a total of 957 reported AIDS cases in NH between 1981 and 2002.

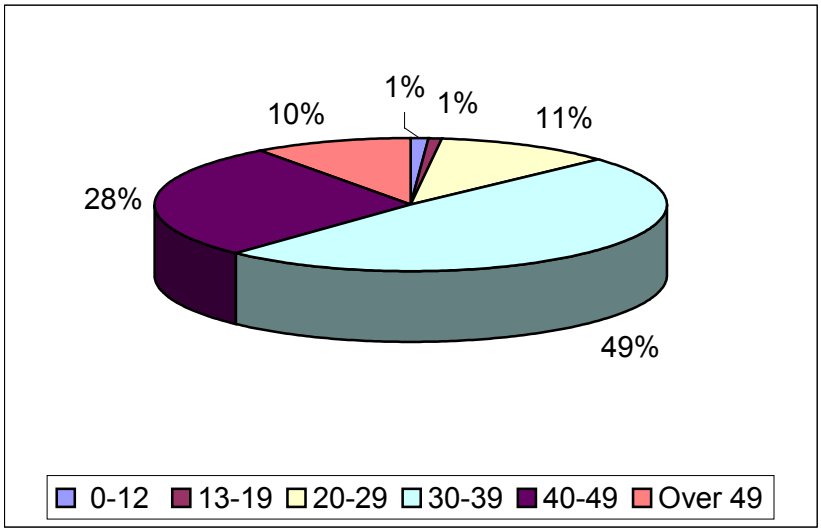
Figure 4. NH AIDS cases, 1998-2002 SOURCE: NH HIV/STD Prevention Bureau, OCPH, DHHS



Unlike AIDS cases where 49% are clustered in the 30-39 age cohort, the HIV age distribution is skewed to the younger 20 to 29 age group and accounts for twice the proportion as compared to AIDS cases in the same time period (25% versus 11%, see Figures 5 and 6). This data is consistent with the expectation that HIV infection data provides

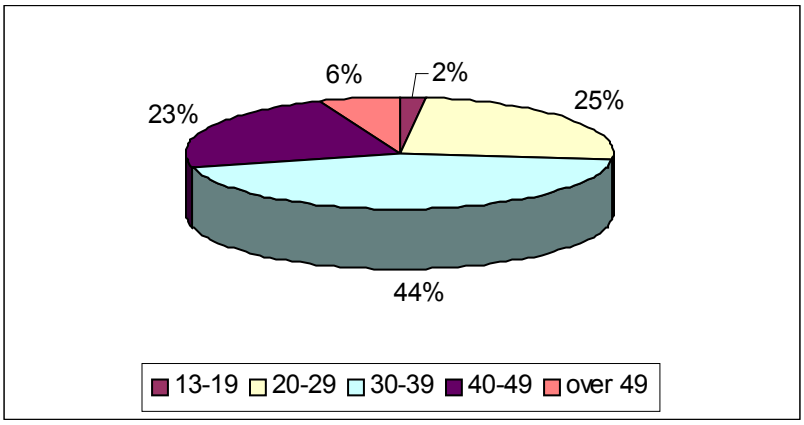
epidemiological data on persons earlier in their diagnosis as opposed to several years after and progression to AIDS. Although some representation of the adolescent and young adult population is evident, these data account for a small proportion (2%).

Figure 5. NH AIDS cases by age group, 1998-2002



SOURCE: NH HIV/STD Prevention Bureau, OCPH, DHHS

Figure 6. NH HIV infection reports, by age, 1998-2002



SOURCE: NH HIV/STD Prevention Bureau, OCPH, DHHS

Impacts of sexually transmitted diseases passed from parent to child

Some STDs can be transmitted through contact with bodily fluids, and may cause harmful health effects to a pregnancy or a newborn. Contrary to some popular beliefs, pregnancy does not provide women or their babies any protection against STDs. In fact, the

consequences of particular STDs during pregnancy can be life threatening for a woman and her baby if undetected and left untreated. This information is presented below in a question & answer format.

Can pregnant women become infected with STDs?

Yes, women who are pregnant can become infected with the same sexually transmitted diseases as women who are not pregnant. A pregnancy does not provide women or their babies any protection against STDs. In fact, the consequence of an STD can be significantly more serious, even life threatening, for a woman and her baby if the woman becomes infected with an STD while pregnant.

How common are STDs among pregnant woman in the United States?

Some STDs such as genital herpes and bacterial vaginosis are quite common in pregnant women in the United States. Other STDs, notably HIV and syphilis, are much less common in pregnant women.

How do STDs affect a pregnant woman and her baby?

STDs can have many of the same consequences for pregnant women as women who are not pregnant. STDs can cause cervical and other cancers, chronic hepatitis, pelvic inflammatory disease, infertility, and other complications.

A pregnant woman with an STD may also experience early onset of labor, premature rupture of the membranes surrounding the baby in the uterus and uterine infection after delivery. STDs can be passed from a pregnant woman to the baby before, during, or after the baby's birth. Some STDs (like syphilis) can cross the placenta and infect a baby while it is in the womb. Other STDs (like gonorrhea, chlamydia, hepatitis B, and genital herpes) can be transmitted from the mother to the baby during delivery as the baby passes through the birth canal. HIV can cross the placenta during pregnancy, infect the baby during the birth process, and, unlike most other STDs, can infect the baby through breastfeeding.

The harmful effects of STDs in babies may include stillbirth, low birth weight, eye infection, pneumonia, neonatal sepsis, neuralgic damage (such as brain damage or lack of coordinated body movements), blindness, deafness, acute hepatitis, meningitis, chronic liver disease, and cirrhosis.

Can STDs be treated during pregnancy?

Certain STDs (like chlamydia, gonorrhea and syphilis) can be treated and cured with antibiotics during pregnancy. There is no cure for viral STDs such as genital herpes and HIV, but antiviral mediations for herpes and HIV may reduce symptoms in the pregnant

woman. For women who have active genital herpes lesions at the time of delivery, a Cesarean delivery may be performed to protect the newborn against infection. A Cesarean delivery may be an option for some HIV infected women.

How can pregnant women protect themselves against infection?

While condom use decreases the risk of contracting some STDs, the only sure way to avoid transmission of sexually transmitted diseases is to abstain from sexual activity.

Points to Remember About STDs

Parents should realize that adolescents are at particular risk for STDs and, potentially, HIV infection. One of the key ways to prevent this is for parents to talk to their children, share with their children their value system, and help their children make responsible choices.

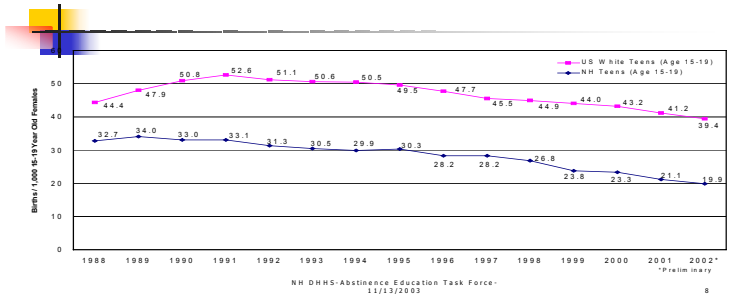
Abstinence is the only certain way to prevent sexually transmitted diseases. Young people who may be thinking about engaging in sexual activity must know the facts about STDs and HIV/AIDS.

New Hampshire Teen Birth rates

As can be seen from Figure 7, the national teen birth rate stands at 39.1 per 10,000 and reflects a downward trend that began in 1991. This same downward trend is reflected in New Hampshire birth rates, where the 19.9 per 10,000 live birth rate is the lowest in the nation.

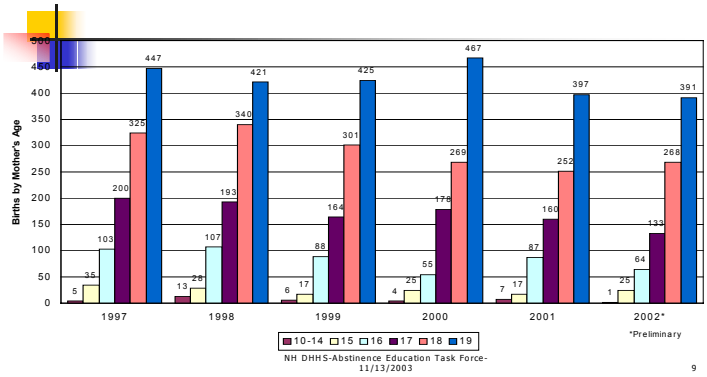
Unfortunately, pregnancy rates cannot be reported, as this information is not collected in New Hampshire. Similarly, pregnancy termination data is not collected, and therefore cannot be trended or reported.

Figure 7. State and US (white) Teen Birth Rates, Ages 15-19, 1988 to 2002



SOURCE: Analysis by Bureau of Health Statistics – OCPH – NH DHHS. Data from Division of Vital Records, NH Secretary of State

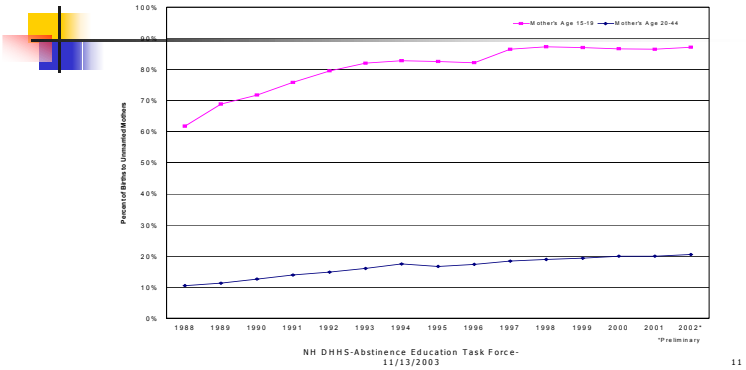
Figure 8: NH Teen Births by Mother's Age, 1997-2002



SOURCE: Analysis by Bureau of Health Statistics – OCPH – NH DHHS. Data from Division of Vital Records, NH Secretary of State

Figure 8 shows the NH teen birth rate presented by age of the mother. There are a few births to girls under the age of 14.

Figure 9, NH births to unmarried mothers



SOURCE: Analysis by Bureau of Health Statistics – OCPH – NH DHHS. Data from Division of Vital Records, NH Secretary of State

Figure 9 illustrates a national trend in childbirth towards a higher percentage of unwed mothers. New Hampshire data mirror this same trend.

As discussed previously, the overall NH teen birth rate is the lowest in the nation; however, the use of an average value hides the fact that many New Hampshire cities and towns have teen birth rates well in excess of the state rate. Table 2 contains all of the NH cities and towns with birth rates significantly above the state average.

Table 2. NH Cities and Towns with Statistically Higher than State Teen Birth Rates, 1998-2002

City/Town	Births to 15-19 Year Old Females	Estimated Female 15-19 Population	Teen (15-19) Birth Rate / 1,000	95% Confidence Interval of the Rate
Allenstown	27	702	38.5	(25.3, 56.0)
Ashland	28	292	95.9	(63.7, 138.6)
Berlin	77	1609	47.9	(37.8, 59.8)
Boscawen	20	457	43.8	(26.7, 67.6)
Claremont	108	2118	51.0	(41.4, 60.6)
Farmington	65	1072	60.6	(46.8, 77.3)
Franklin	85	1433	59.3	(47.4, 73.3)
Hillsborough	38	895	42.5	(30.0, 58.3)
Hinsdale	26	644	40.4	(26.4, 59.2)
Laconia	107	2731	39.2	(31.8, 46.6)
Lebanon	67	1921	34.9	(27.0, 44.3)
Littleton	41	936	43.8	(31.4, 59.4)
Manchester	709	16586	42.7	(39.6, 45.9)
Milton	27	640	42.2	(27.8, 61.4)
Nashua	415	12867	32.3	(29.1, 35.4)
Newport	52	902	57.6	(43.1, 75.6)
Northfield	40	926	43.2	(30.9, 58.8)
Northumberland	23	450	51.1	(32.4, 76.7)
Ossipee	29	634	45.7	(30.6, 65.7)
Pittsfield	45	745	60.4	(44.1, 80.8)
Raymond	55	1767	31.1	(23.4, 40.5)
Rochester	225	4651	48.4	(42.1, 54.7)
Seabrook	55	843	65.2	(49.2, 84.9)
Somersworth	78	1860	41.9	(33.1, 52.3)
Swanzey	37	989	37.4	(26.3, 51.6)
Winchester	44	685	64.2	(46.7, 86.2)
New Hampshire	4872	214219	22.7	(22.1, 23.4)

Note: City/Town rates presented are those where the rate is significantly different from the state at the 95% confidence level

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SOURCE: Analysis by Bureau of Health Statistics – OCPH – NH DHHS. Data from Division of Vital Records, NH Secretary of State

Youth Sexual Behavior

Teen pregnancy and STD transmission occur as a direct result of the sexual behavior practiced by our youth. To better understand this behavior, and frequency at which it occurs, the Youth Risk Behavior Survey collects data from high school students (grades 9 through 12) in 6 areas of risky behaviors. The YRBS is administered nationally, and thus allows for comparison between states as well as for comparisons between years within states, assuming that enough students participate in the survey to make the results statistically meaningful. Student participation is voluntary, and each school's parental permission policy is followed before the survey starts.

Sexual behavior data were collected from 31 New Hampshire high schools in the spring of 2003. Participating schools surveyed their full student bodies and a total of 16,404 students completed the 99-item questionnaire. The results of the survey are continued in Table 3. In order to allow for comparisons over time the table also contains data from 1993 and 1995, the only other available years where enough students participated to allow for comparison of data.

Table 3 YRBS results for years 1993, 1995, and 2003

Category	1993	1995	2003
% Students who ever had sex	54.3	46.4	41.5
% Students who had sex before age 13	7.7	5.4	3.9
% Students who have had intercourse with 4 or more people in their life.	15.9	13.3	10.1
% Students who have had intercourse but not during the last 3 months	31.5	27.2	25.4
% Students that used drugs or drank alcohol prior to last intercourse	21.9	22.6	21.6
Of students that had sexual intercourse in the last 3 months, the % that used condoms	51.1	51.5	56.4
Of students that had sexual intercourse in the last 3 months, the % that used birth control pills	NA	29.6	33.3
% Students who have been pregnant or impregnated someone else	4.1	4.7	2.5

SOURCE: Youth Risk Behavior Survey, 1993, 1995, 2003

As can be seen from Table 3, trends over time are generally encouraging in that more students are reporting abstinence. Less encouraging is the lack of change in the use of drugs and alcohol, and that fewer students reported being taught about AIDS or HIV infection in

school. The surveys also document an increase in both condom and birth control pill use by students over the last decade.

Tapping into Teen Concerns, Perceptions and Behaviors: 1998/99 Multi-Community Report (The Teen Assessment Project, UNH Cooperative Extension, 2000) discusses aggregate findings from surveys administered to 7th through 12th grade students in five school districts from the Spring of 1998 to the Winter of 1999. A total of 9,105 surveys were analyzed, representing 85% of participating schools' student populations. The report found that parents supervising children and knowing where they are and what they are doing is an important factor in preventing adolescent sexual activity. Teens who reported low parental involvement of this type were more than three times as likely to also report sexual activity than teens that reported high parental involvement (52% vs. 16%). Additionally, the report also found that teens who did not believe that their parents thought it was wrong for teens their age to have sex were more than three times as likely to report being sexually active than teens who believe their parents think it is wrong (52% vs. 17%).

Points to remember about NH teen sexuality

There is an overall downward trend in teen births across the county. New Hampshire is leading the way, with a teen birth rate of 19.9/1000 which is the lowest in the nation.

The percentage of New Hampshire teens reporting abstinence is increasing.

Despite the state's low teen birth rate, there are many cities and towns where teen birth rates significantly exceed the state average.

More New Hampshire females are bearing children out of wedlock, a trend they share with females across the country.

Measuring Program Success or Failure

In order for government funded projects to demonstrate their worth it is important that the outputs of the project are measurable. While this sounds easy in theory, in practice measuring results for programs such as the Section 510 Program are complicated by such factors as:

- The difficulty in drawing cause-and effect relationships in studies where there is no random assignment of participants to different programs, and where the teen is potentially influenced by many factors not under the control of the study (i.e., parents, friends, media, celebrity images, etc).

- Having a large enough group of participants in the study to make the results sufficiently powerful and sensitive enough to detect subtle changes in behavior.

- Changes and knowledge, beliefs, and behavior do not occur overnight, so the study period must be long enough to cover the change that is being measured.

The above concerns are even more pronounced in programs such as media campaigns that attempt to change community norms and behavior.

Because of these measurement difficulties, local program evaluation is usually based on pre and post test changes in knowledge while media campaigns are often judged on the percentage of the target audience receiving the message. Some media campaigns do validate attitude and behavioral changes using public opinion polls, but this is very expensive.

National Evaluation of Section 510 Program

Congress addressed many of the questions raised about measuring Section 510 program success or failure by funding an independent evaluation of Section 510 programs in the Balanced Budget Act of 1997. This federal effort is a national study of sufficient size and statistical power to measure program success or failure with a degree of statistical accuracy that would be impossible in small local programs.

Specifically the federal study is designed to determine the extent to which abstinence programs:

1) Strengthen knowledge and attitudes supportive of abstinence;
2) Induce more youth to embrace abstinence from sexual activity as a personal goal;
3) Reduce sexual activity among youth;
4) Persuade sexually experienced youth to become and remain abstinent;
5) Lower the risk of STDs; and
6) Lower the risk of non-marital pregnancies.

A preliminary report on the first four years of program operational experiences was completed in April 2002. This first report highlights the range of abstinence education programs that are operating, and provides detailed implementation information on 11 programs that were selected to be in the national evaluation.

A second report, which is to focus on the success of the study programs in achieving their short-term goals of changing youths' attitudes and other mediators of teen sexual activity, is expected to become public in early 2004.

The final study evaluation report, which is expected to measure behavioral changes, is scheduled for completion in 2006.

The national evaluation is being conducted by Mathematica Policy Research, Inc. A copy of the preliminary report is available at http://aspe.hhs.gov/hsp/abstinence02/ch1.htm.

Sources of statistical information

As described above, no program can be considered efficient and successful unless it is possible to measure a baseline followed by measures of change from that baseline. Fortunately, there are data sets available to help evaluate the success of abstinence programs. A summary of the key data sources is provided below.

The Division of Vital Records in the Office of the Secretary of State is responsible for collecting information on births to NH residents and births occurring in NH. Hospitals and midwives report the information to the Division of Vital Records. Out-of-state births to NH residents are collected by the state where the birth occurs and reported to NH through an interstate exchange agreement.

Birth data consists of information from a birth certificate including:

- Newborn's sex, weight, period of gestation, date of birth and congenital anomalies,
- Mother's and father's residence, age, race and ancestry, and
- Many characteristics of the pregnancy and birth including maternal smoking and alcohol use, method of delivery, use of prenatal care and complications of the pregnancy.

The birth data is typically considered complete and available for analysis approximately eight months after the close of a calendar year. The most recent birth data available for analysis is calendar year 2002.

The Youth Risk Behavior Survey (YRBS) is a good source of information on teen sexuality, and in fact was the source of the data presented earlier in this report. The YRBS has been in existence for more than 20 years and now, as then, the purpose of the survey is to identify and measure risky behaviors in young people. It is important to begin these surveys early since such behaviors are often established early in life. These behaviors, often established during childhood and early adolescence, include sexual behaviors as well as drug/alcohol abuse and violence. As mentioned previously, YRBS data can only be compared between survey years if there were enough participants to make a certain year statistically significant.

In short, the YRBSS was designed to:

- Determine the prevalence of health risk behaviors.
- Assess whether health risk behaviors increase, decrease, or stay the same over time.
- Examine the co-occurrence of health risk behaviors.
- Provide comparable national, state, and local data.
- Provide comparable data among subpopulations of youth.

- Monitor progress toward achieving the Healthy People 2010 objectives and other program indicators.

YRBS data is available through the state, and can also be found at the following federal URL: http://www.cdc.gov/nccdphp/dash/yrbs/about_yrbss.htm.

Abstinence links reviewed by the Task Force

The relevant federal government web site is:

US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Maternal and Child Health, Section 510 Program: http://www.mchb.hrsa.gov/programs/adolescents/abstinence.htm

The relevant New Hampshire web site is:

NH Department of Health and Human Services
http://www.dhhs.state.nh.us/DHHS/DHHS_SITE/Special+Initiatives/abstinence-task-force.htm

For a comprehensive listing of abstinence-only programs the reader is referred to the National Abstinence Clearinghouse: http://www.abstinence.net.

(Note: Listing of particular web addresses is not meant to imply endorsement or approval by the State of New Hampshire of any of the material maintained therein.)

Education Programs Subgroup

What has worked in other states?

The Task Force notes that since the availability of the Section 510 federal funds (over $250,000,000 nationally since 1997), there has been a notable increase in both the quantity and quality of abstinence-only curricula. These new offerings range from 90-minute interactive lectures to multi-week programs featuring the latest educational tools.

The members of the Education Programs Subgroup offered the following programs as examples of programs that have experienced some success in other states. (Note: Listing of these programs in this report does not imply any form of endorsement or approval of these programs by the State of New Hampshire.)

Table 4. Characteristics of Selected Abstinence Programs

Program Name	Type of Program	Measure of Success
Louisiana GPA (Governor's Program for Abstinence)	Four part Program • community projects • abstinence-only curriculum for seventh grade public school students • Abstinence Clubs for high school students • clearinghouse center/website	Abstinence clubs in 250 high schools in Louisiana. There are more than 5,000 students in the clubs. Program will have 40,000 students in the 7th grade curriculum for the 2003-2004 school year. National Abstinence Clearinghouse has rated the GPA website as one of the best abstinence sites on the web.
Why Knows Abstinence Education? Program		
Choosing the Best program	Classroom instructing tailored to fit 3 age groups. Curriculum includes role playing, video case studies, interactive exercises and small-group discussions.	Pre- and post-test demonstrate changes in attitudes about premarital sex.
FACTS program	FACTS is a highly successful abstinence project developed through a grant from the Department of Health and Human Services. The FACTS Abstinence Curricula include 5th and 6th grades, Middle School, Senior High, Parent Materials, and a Parent-Teen Workshop.	
SHARE program	90 minute programs, 2 days for middle school age and 5 days for high school age, includes goal setting, defining abstinence, second virginity, and other topics, and learning to resist sexual pressure.	Personal endorsements
Abstinence speakers	Generally a lecture format	

What abstinence promoting activities could be funded?

Table 5 lists specific items that the Education Programs Subgroup recommends as part of New Hampshire's abstinence-only education program. The first column contains recommendations that could be addressed at the gubernatorial and legislative levels, while the second column lists the specific abstinence-only program activities the Subgroup believes would be the most effective locally.

Table 5. Recommendations of Education Programs Subgroup

Abstinence policy recommendations	**Recommended specific abstinence program activities**
Governor's Directive on Abstinence Education (Language Specific)	School Curricula *See "What has worked"
NH Pregnancy Termination Reporting (for measurable outcomes)	Speakers (List of speakers available)
Revise the statute on instruction on sex educating (Mandatory Heath Education)	Promote Healthy Lifestyle— High school clubs
Governor's Proclamation	Resource bank – books, videos, brochures, websites, posters
	Public Service Announcements (PSAs) (TV, radio, print)
	Develop drama teams (travel Teams)
	Parent education teams

What types of education can be provided?

Members of the Education Programs Subgroup looked primarily at character-based education, which also includes some social skills.

The Education Subgroup suggested teaching risk-eliminating lifestyles regarding alcohol, drugs, tobacco, genital activity, and violence in order to promote:

- Character building
- Responsibility
- Self-discipline
- Refusal skills
- Communication skills
- Decision-making skills
- Good citizenship
- Creative and critical thinking skills

Target Audience Subgroup

What age groups should abstinence educators work with?

The Target Audience Subgroup reported that ages 10 – 14 are currently the preferred target age group within New Hampshire's program, and that an abstinence contractor received a waiver to work with ages 12 – 16 in the Nashua area. The Target Audience Subgroup reported that in Colorado, the preferred age group is 12 – 19.

The Target Audience Subgroup described a gradation of activities according to ages, as follows:

- The youngest need an abstinence appropriate message, but not a 10 hour program. There is a concern that providing very young children with too much information too early may be counterproductive.
- For 12 – 16 year olds, curricula program content and length needs to be age-appropriate.
- Parents should be included in abstinence activities.

The Target Audience Subgroup quoted a poll that showed the majority of parents want abstinence education. The Subgroup also reported that 2 of 3 teens who have had sex wish they had waited longer (8 of 10 girls and 6 of 10 boys). The Target Audience Subgroup felt that parents often underestimate their own influence. The Target Audience Subgroup stated that age 10 is too soon, that kids will forget the message, as the onset of sexual activity is 4 – 5 years in the future. The data show that that in 1990, only 8 girls less than 13 years of age gave birth in NH, and in 1996, it was 7 girls. The Target Audience Subgroup agreed with the federal Section 510 guidelines that recommend that Section 510 funds should be spent on those youth at highest risk.

Recommendations of the Target Audience Subgroup*:*

1. Work primarily with youth in the 12 – 19 year old bracket.
2. When a high school program graduates youth to college, the abstinence program should continue on to the college level.
3. Create an age appropriate program, approximately 2 hours in length, for grades 6 through 8.
4. Involve parents in every aspect of abstinence programs.
5. Stop funding sex education programs that shut parents out except as required by federal law.

The Task Force noted that there is a wide variety of abstinence only curricula on the market today, much of it very well funded and professionally done. In most cases there will be "off the shelf" curricula available for almost every age group an abstinence educator may want to work with.

Identification of populations at increased risk

Risky behavior among young people (smoking, drinking, sexual activity, violent behavior, and suicide) have traditionally been linked to factors such as race, ethnicity, family income and whether teens live within a one or two parent household. Other research suggests that factors such as school performance, how young people spend their unsupervised time, the attitudes and beliefs of their friends, and interfamily relationships are also very important determinates of future behavior. Lastly, community norms and patterns affect the way teens behave.

However they are defined, the Task Force felt it was important to recognize populations at high risk for sexual activity outside of wedlock. This is an important consideration because:

- It is critical that limited abstinence-only program resources are targeted to where they will do the most good.
- Federal implementation guidance encourages programs supported by Section 510 funding to focus on those groups most likely to bear children out of wedlock.

The Task Force did not choose to make specific recommendations regarding special needs populations, but instead recommends that community programs take special needs populations into consideration when planning for local activities.

Parents as a special target audience

The Task Force felt strongly that parental involvement in the education of their children is a key component of success in avoiding premarital sex as well as other risky behaviors such as the use of drugs and alcohol.

Marketing Subgroup

Encouraging participation at the community level

The Marketing Subgroup offered the following suggestions for encouraging the participation of community groups in the Section 510 Program:

1. Make the application process quick and easy, and use plain English in the questions on the forms.

2. Advertise the availability of funding in community papers.

3. Limit the number of curricula to a few proven choices. This leaves less room for misinterpretation and allows for more sharing of resources and knowledge.

4. Highlight the successes of currently funded projects. This is helpful when presenting the program to a new organization – statistics are needed. If possible show the statistics when the program began, a year later, at three, and five years, whatever is available.

5. Shorten request for proposals, and write in plain English.

6. Move towards an on-line application process to take advantage of advances in computer technology.

7. Receive the endorsement of the Governor or other high-ranking state official. Having a program, such as the program in Louisiana, endorsed by a State official helps local abstinence programs and is perceived as more official. Organizations within the State will take abstinence-only programs more seriously if abstinence programs have this type of leadership.

Organizations or groups that should be made aware of the Section 510 Abstinence-only Program:

The Marketing Subgroup recommended that the following organizations be made aware of the abstinence-only program.

1. Youth serving organizations.
2. Local health departments.
3. Local boards of education.
4. Faith-based organizations.
5. Universities and colleges.

All of these are potential training grounds, but abstinence-only programs need to make connections through local men and women working with each of these organizations, so that they are able to promote abstinence-only programs themselves. If abstinence-only programs have developed contacts in certain areas of the state already, efforts should be focused in those areas first.

The Marketing Subgroup also felt that the way to effectively market abstinence-only education is to have representatives in each county that will make the connections with their own local organizations. Who better to make connections with individuals, than people who know those individuals? Local representatives will need to know which of the above organizations exist in their communities. The local representative will have more knowledge of local radio stations, television networks, newspapers and other sources of advertising and fundraising in their area.

Program Location Subgroup

The Task Force also considered the Section 510 Program and where it might best fit in the structure of state government. The actual "home" of the Section 510 program is different

from state to state, and variously resides in Departments of Health and Human Services, Departments of Education, or in Governor's Offices, depending on the state. Reasons both pro and con to place the program in the Governor's Office as opposed to its current location in DHHS are listed in Table 6.

Table 6. Location of Section 510 Program – Pro and Con

PRO	CON
High visibility	Governors only serve a 24 month term, and an incoming Governor may place a higher priority on other projects.
Program may sound more "official", hence more acceptable	Governors have many obligations and demands on their time.
	Fewer staff in Governor's Office to provide support to the abstinence program.
	Program may be viewed as "political", hence less acceptable.

The Program Location Subgroup offered the following recommendations:

1. Place the Section 510 Abstinence-only Program in the Governor's Office.
2. Have an abstinence program manager reporting directly to the Governor. The program manager should have the following characteristics:
   a. Fully committed to abstinence-only.
   b. Have knowledge of pertinent federal regulations.
   c. Be proactive in dealing with abstinence-only groups in the state of New Hampshire.
   d. Be given enough authority to make the program succeed.
   e. Be fair in dealings with abstinence-only groups.
   f. Be strong enough to withstand pressure from opposing lobbying groups.
   g. Be financially astute.
   h. Be a self-starter.
   i. Be open-minded.
   j. Have an open door policy.

Issues addressed by DHHS

The legal obligations of fathers to their children

One of the consequences of out of wedlock birth that does not change is the legal obligation of a father for his children. This section of the final report describes these obligations, and the process for establishing paternity.

In terms of paternal obligations, the father of a child born to unwed parents is liable to the same extent as the father of a child born to married parents under RSA 168-A:1. Specifically, he is responsible for the reasonable expenses of the pregnancy, birth, and general support. New Hampshire uses a uniform set of Child Support Guidelines in all child support cases.

Paternity is determined either by filing a petition to establish paternity in Superior or Family Division Court or by the filing of an affidavit of paternity signed by both parents. State law (RSA 5-C) requires the following procedures:

(1) Where there is any question of paternity the matter must be resolved by the court unless paternity is acknowledged by the parents and an affidavit of paternity is completed and notarized either at the hospital or birthing facility, or at the clerk's office in the city or town where the child was born.

    a. Before the parents sign an affidavit of paternity, the statute requires that they will both be fully informed of their rights and obligations as well as alternatives to acknowledging paternity by affidavit.

(2) When an affidavit of paternity is signed by the parents or as ordered by a court, the resulting affidavit of paternity establishes paternity and a copy is sent to the Division of Vital Records to be matched to the birth record.

    a. The father or mother signing the affidavit of paternity can take back the acknowledgement and let a court decide the matter.

    b. The name of the father and the surname of the child are entered onto the birth certificate after a court has established paternity.

If public assistance is provided to the pregnant woman or the child, the mother is required to provide the name of the father, if known to her. The Department will then initiate a paternity action if appropriate and pursue a support order based on the child support guidelines. When a mother is receiving public assistance, Temporary Assistance to Needy Families (TANF), which subrogates the right to the State to establish and collect support on behalf of the dependent child, the Department recoups the cost of public assistance not to exceed the grant amount. So for example, if the TANF grant amount is $300 per month and

the ongoing child support obligation actually received by the Department from the non-custodial parent is $350 per month, $50 of support will be paid to the custodial household in addition to the public assistance grant received from the State.

What is the state's financial obligation for out of wedlock children?

One way to estimate the cost of raising children is the foster care payment system, which is the reimbursement to the providers of foster family care as they work with the child and his or her family. The rate includes provision of food, shelter, daily supervision, school supplies, and special occasions such as the child's birthday and other holiday celebrations, clothing, and personal incidentals such as personal hygiene, leisure activities, or educational needs. At this time the costs for general care to support a foster child from birth through age 18 would be $91,876. Costs of covering a specialized care foster child for the same time period would be $140,793.

Another means of estimating child rearing costs is to use the USDA report entitled *Expenditures on Children by Families, 2002* (USDA Center for Nutrition policy and promotion misc pub 1528-2002). This publication estimates that the cost of raising a child born in 2002 until age 17 would be $231,860.

Finally, the Task Force notes there is a Commission created by Ch 277.1, Laws of 2003, (Commission to study child support and related child custody issues) which is also currently examining the issue of the cost of raising a child in NH. The Commission is in the process of contacting UNH to see if it can get an economist to assist in determining the cost. Any child rearing cost estimates developed by the Commission would be of interest to the Task Force. The study commission's final report is due on December 1, 2004.

RECOMMENDATIONS

The Task Force offers the following recommendations for the improvement of the Section 510 Abstinence-only Education Program:

- Focus the Section 510 program on funding the work of community programs who are directly involved with teaching abstinence-only to young people. Funds must be made available in a way that is "user-friendly" to applicants, and DHHS needs to devote the time and effort needed to coordinate the Section 510 Program. Priority must be placed on populations at greatest risk.

- Once community program needs are met, an approved media program would ensue, but refocus the message on promoting youth participation in community level abstinence programs. Other abstinence-only mass media messages should be funded only after the needs of the community programs are met.

- Abstinence-only curricula must be more than a "just say no" message, and teach the social and decision making skills young people need to avoid premarital sexual activity.

- Maintain public oversight over the Section 510 program through the committee and periodic presentations to the HHS Oversight Committee established under RSA 126-A:13.

- In addition to improving the Section 510 Program, the Task Force or similar group should seek additional support for statewide abstinence-only activities by applying for federal dollars available through the SPRANS Program.

APPENDIX A

Federal and state criteria for abstinence only programs

Section 510 Federal Abstinence Education Criteria*	State Abstinence only Criteria
(A) Has as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity.	1. Technically accurate and up to date with a sound educational methodology.
(B) Teaches abstinence from sexual activity outside marriage as the expected standard for all school age children.	2. Able to increase knowledge and develop refusal skills.
(C) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems.	3. Address federal program priorities.
(D) Teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity.	4. Positive in its approach (not shaming).
(E) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.	5. Gender fair (treats boys and girls equally).
(F) Teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents and society.	6. Racially, ethically and culturally non biased and relevant for a diverse population.
(G) Teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances.	7. Developmentally appropriate for both boys and girls aged 16 and under.
(H) Teaches the importance of attaining self-sufficiency before engaging in sexual activity.	8. Does not teach or promote religion as part of the program.
*Pursuant to federal guidelines, it is not necessary to place equal emphasis on each element of the definition; however, a project may not be inconsistent with any aspect of the abstinence education definition.	9. Broad in scope, covers a wide range of complimentary and relevant topic areas.
	10. Cost to implement is reasonable.

APPENDIX B

Text of Proposed Marketing Letter

They are your children… we want to help!
By now, you must be aware of how different things are for kids growing up these days. Not only different but more dangerous…a lot more dangerous…in fact, DEADLY!
We want to help you to help your children in meaningful ways and protect them from things they are too young to fully understand.
We are your NH abstinence education team. We are dedicated to the best for you and the children of New Hampshire.

In the past the message, which has gone out, has been "safe sex". We are now going to the highs and to the more excellent step. It is the step, which certainly eliminates the many dangerous physical, emotional, social, economic, medical and family aspects of juvenile sexual activity.

If you have not yet guessed what it is…"The safest sex…abstinence"…for your children to wait until they are fully adults and married!

We are following mandates such as those of the United States Congress and the funding requirements set forth for Abstinence Only Education. We have been diligent as a cooperation of various government agencies, local organizations and expert volunteers who truly care about the future of New Hampshire's greatest resource… our children. We believe nobody cares more than we do and we are all about proving it. We have no other motive or agenda. We do not profit from this endeavor as others who teach a different message do.

You can expect from us the tools that you need to educate your children and to inform the others that have influence in the lives of your children. This includes tools such as proven teaching programs, tools such as positive peer presentations by teens that have as their theme such statements as…"No not everyone is doing it… the coolest people are waiting until later!", tools such as the true and heart rendering stories of young people who did not get the abstinence message soon enough to keep them out of trouble and danger, tools such as how parents can be

more involved in the decision making of their children and tools like how to talk to your kids about "the difficult" subjects.

You will be hearing and learning more about this urgent endeavor. Do not be turned off, deceived, or misled by the negative thinking folks who claim abstinence does not work. We know for a fact it certainly does and we know that it is a standard that is both wise and doable, one that your kids will respond to. The sooner we get this truth out the fewer "casualties" there will be. Please help us contact any of the local organizations, schools, families and community leaders that are compassionate to this most worthwhile cause. We welcome your input!